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STATE OF DELAWARE
**DEPARTMENT OF STATE**
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL PRACTICE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: WWW.DPR.DELAWARE.GOV

# Verification of Physician Assistant Education

| | |
|---|---|
| Institution:_____ | Applicant's Name:_____ |
| Address:_____ | Address:_____ |
| City/State/Zip:_____ | City/State/Zip:_____ |

**This section is to be completed by applicant.**

**Be sure to sign the form.**

Last Name:_____ First Name:_____

SSN:_____ DOB:_____

Name if Different from Above:_____

I am applying for licensure as a Physician Assistant in the State of Delaware. Before my application can be reviewed, verification of my Degree or Certification is required. I am authorizing the release of the information requested on this form.

Signature: _____ Date: _____

**Program Participation to be completed by the Institution:**

Our records indicate that _____ was enrolled in
(Type / print individual's name: Last, First, middle)
our institution during the following dates (mm/dd/yyyy):

| From | To |
|---|---|
| _____/_____/_____ | _____/_____/_____ |
| Month Day Year | Month Day Year |

This individual (check one):

_____ was awarded the degree of _____ on _____/_____/_____
Month Day Year

_____ was NOT awarded a degree (please attach an explanation)

**Certification**

*****AFFIX OFFICIAL SEAL HERE**

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Name:_____ Signature:_____

Title:_____ Date of Signature: _____

Tel: _____ Fax: _____ E-mail: _____

*****RETURN COMPLETED FORM WITH SEAL AFFIXED TO THE BOARD ADDRESS ABOVE. THANK YOU.**